Chart Review – Data Collection Form
Treatment of LTBI

Clinic _____
Date of Abstraction _____
Initials of Abstractor _____

DOB _____
Gender: _____ M _____ F

Demographics Documented:

	Yes	No		Yes	No
Address provided			Work #		
Home phone #			Msg phone #		

Race:

	White		Pacific Islander
	Hispanic		Native American/Alaskan
	Black		Other
	Asian		Unknown

Nation/Country of Origin: Date of arrival into U.S. No documentation of arrival date

	United States	----------	----------
	Mexico		
	Other		

Bi-National of Mexico:

	Yes	No		
Travel to and from Mexico				
Family address in Mexico				

Reason for TST:

Medical Risk	Population Risk	Administrative	Unknown

TST Data:

Date applied		----------	
Date read		No return for reading	
Results	mm	Results not recorded	
Read by	>>	No documentation	

BCG Data:

	Yes	No	"unknown" per pt	No documentation in record
Asked re BCG			----------	
Hx of BCG				
Documentation of BCG			----------	

HIV Screening

	Yes	No			
Offered			Results documented		
Done			Pt refused testing		

CXR Date:

	Normal		Granulomas only
	Abnormal / not TB		Other
	Old TB		

Risk Factors for Hepatoxicity:

	Alcohol		Multiple Meds
	Drug Injection		Other
	Chronic HCV		Asked, but denies risk factors
	Chronic HBV		NOT ASKED
			NOTHING NOTED IN RECORD

Allergies _____ Yes _____ No
Treatment for LTBI recommended _____ Yes _____ No
Treatment offered _____ Yes _____ No
Treatment refused _____ Yes _____ No
Other reason tx not started _____
Treatment start date _____ Medication _____ Dosage _____
DOT _____ Yes _____ No
Wt _____# _____ Kg.

LFTs indicated _____ Yes _____ No
If Yes: Baseline drawn _____ Yes _____ No
F/U LFTs _____ Yes _____ No

Symptoms of Hepatitis with date of onset:

	None		Nausea
	Vomiting		Headache
	Abdominal Pain		Fever
	Anorexia		Diarrhea
			Other

Treatment Plan: _____ 6 mo _____ 9 mo _____ 12 mo
Treatment completion date _____ _____ months tx _____ over _____ months

Reason Treatment Not Completed:

	Still on meds		Active TB developed	
	To complete by when?		Adverse effect of med	
	Death			
	Moved (f/u unknown)			

Cure-TB Referral Forms:

	Yes	No	When
Available in clinic			----------
Referral made to C-TB			
Response from C-TB			

Chart Review – Data Collection Form
Treatment of Active TB

1. COUNTY
2. STATE
3. CHART ABSTRACTOR
4. DATE OF ABSTRACTION

CASE INFORMATION

5. ID NUMBER
6. STATE CASE NUMBER (RVCT#)
7. DOB ___/___/____
8. SEX 1=M 2=F 9=U
9. HOSPITALIZED AT DIAGNOSIS 1=Y 2=N 9=U
10. ALLERGIES _____

(This means the diagnosis was made when the patient was hospitalized, not that specimens which led to diagnosis were collected during hospitalization)

SITE

11. SITE OF DISEASE
    1. PULMONARY 2. EXTRAPULMONARY 3. BOTH

(pleural=extrapulmonary)

12. ACCORDING TO MEDICAL RECORD, BASIS OF DIAGNOSIS
    1. CULTURE 2. SMEAR 3. CLINICAL FINDINGS
    4. PROVIDER DX 5. OTHER _____

THERAPY METHOD

13. DOT
    1. TOTAL 2. DOT AND UNSUPERVISED
    3. UNSUPERVISED 9. DK

THERAPY START/STOP DATES (This should be first date that patient started therapy for this episode of TB, even if therapy was started in hospital and not by the health department.)

14. DATE THEREAPY STARTED PER RECORD ___/___/_____
15. PARTIAL DATE? 1=Y 2=N 9=U
16. DATE THERAPY STOPPED PER RECORD ___/___/_____
17. PARTIAL DATE? 1=Y 2=N 9=U

REASON THERAPY STOPPED

18. REASON THERAPY STOPPED PER RECORD
    1. COMPLETED THERAPY
    2. MOVED
    3. LOST
    4. UNCOOPERATIVE OR REFUSED
    5. NOT TB
    6. DIED
    7. OTHER _____
    8. UNKNOWN

TREATMENT PLAN

IN-HOSPITAL

19. A. ISONIAZID _____
    B. RIFAMPIN _____
    C. PZA _____
    D. ETHAMBUTOL _____
    E. STREPTOMYCIN _____
    F. OTHER _____
    G. DON'T KNOW _____

OUTPATIENT

20. INITIAL REGIMEN/LENGTH OF TIME IN MONTHS PLANNED FOR EACH DRUG
    A. ISONIAZID _____
    B. RIFAMPIN _____
    C. PZA _____
    D. ETHAMBUTOL _____
    E. ETHAMBUTOL UNTIL DRUG SUSCEPTIBILITIES AVAILABLE
    F. STREPTOMYCIN _____
    G. OTHER _____
    H. DON'T KNOW _____

    FREQUENCY OF ADMINISTRATION
    2X/WK _____
    3X/WK _____
    DAILY _____

21. FIRST EIGHT WEEKS
    INITIAL REGIMEN/LENGTH OF TIME IN MONTHS PLANNED FOR EACH DRUG
    A. ISONIAZID _____
    B. RIFAMPIN _____
    C. PZA _____
    D. ETHAMBUTOL _____
    E. ETHAMBUTOL UNTIL DRUG SUSCEPTIBILITIES AVAILABLE
    F. STREPTOMYCIN _____
    G. OTHER _____
    H. DON'T KNOW _____

    FREQUENCY OF ADMINISTRATION
    2X/WK _____
    3X/WK _____
    DAILY _____
    OTHER (specify) _____

22. NEXT MONTHS TO COMPLETION
    A. ISONIAZID _____
    B. RIFAMPIN _____
    C. PZA _____
    D. ETHAMBUTOL _____
    E. ETHAMBUTOL UNTIL DRUG SUSCEPTIBILITIES AVAILABLE
    F. STREPTOMYCIN _____
    G. OTHER _____
    H. DON'T KNOW _____

FREQUENCY OF ADMINISTRATION DURING REST OF TREATMENT

2X/WK _____
3X/WK _____
DAILY _____
OTHER (specify) _____

TREATMENT DELIVERED

HOSPITAL

23. APPROXIMATE NUMBER OF DOSES INGESTED IN HOSPITAL
    - A. ISONIAZID _____
    - B. RIFAMPIN _____
    - C. PZA _____
    - D. ETHAMBUTOL _____
    - E. STREPTOMYCIN _____
    - F. OTHER _____
    - G. DON'T KNOW _____

OUTPATIENT – DOT

24. DOSES COUNTED – FIRST EIGHT WEEKS
    - A. ISONIAZID _____
    - B. RIFAMPIN _____
    - C. PZA _____
    - D. ETHAMBUTOL _____
    - E. STREPTOMYCIN _____
    - F. OTHER _____
    - G. DOSES NOT COUNTED FOR ANY MEDICATIONS

25. DOSES COUNTED – NEXT MONTHS TO COMPLETE THERAPY
    - A. ISONIAZID _____
    - B. RIFAMPIN _____
    - C. PZA _____
    - D. ETHAMBUTOL _____
    - E. STREPTOMYCIN _____
    - F. OTHER _____
    - G. DOSES NOT COUNTED

OUTPATIENT, SELF-ADMINISTERED

26. NUMBER OF MONTHS OF REFILLS DOCUMENTED
    - A. ISONIAZID _____
    - B. RIFAMPIN _____
    - C. PZA _____
    - D. ETHAMBUTOL _____
    - E. STREPTOMYCIN _____
    - F. OTHER _____
    - G. N/A _____

INTERRUPTIONS IN THERAPY

IF THERAPY INTERRUPTED, PERIODS OF INTERRUPTION OF LONGER THAN 14 DAYS. (This should be interruption of all anti-TB medications)

27. DATE THERAPY INTERRUPTED ___/___/_____
28. DATE THERAPY REINITIATED ___/___/_____
29. DATE THERAPY INTERRUPED ___/___/_____
30. DATE THERAPY REINITIATED ___/___/_____
31. THREE OR MORE INTERRUPTIONS OF LONGER THAN 14 DAYS EACH 1=Y 2=N 9=U

TREATMENT HELD OR CHANGED

32. WHERE ANTI-TB MEDS HELD OR CHANGED?

(Please answer yes if even one anti-TB meds were held or changed)

IF YES

33. A. PLATELETS <100,000 1=Y 2=N 9=U
    B. CREATININE >2.0 1=Y 2=N 9=U
    C. BILIRUBIN >2.0 1=Y 2=N 9=U
    D. SGOT> 3X UPPER LIMIT OF NORMAL 1=Y 2=N 9=U

34. OTHER REASONS DRUGS HELD OR CHANGED (SPECIFY)

RISK FACTORS

35. HOMELESS PER PROJECT DEFINITION 1=Y 2=N 9=U
36. HOMELESS ACCORDING TO REC PER RVCT DEF 1=Y 2=N 9=U
37. EXCESS ALCOHOL USE PER PROJECT DEF 1=Y 2=N 9=U
38. EXCESS ALCOHOL ACC TO REC PER RVCT DEF 1=Y 2=N 9=U
39. INJECTING DRUG USE PER PROJ DEF 1=Y 2=N 9=U
40. INJECTING DRUG USE PER RVCT DEF 1=Y 2=N 9=U
41. NON-INJECTING DRUG USE PER PROJ DEF 1=Y 2=N 9=U
42. NON-INJECTING DRUG USE PER RVCT DEF 1=Y 2=N 9=U

HIV

43. HIV STATUS
    0. NEGATIVE
    1. POSITIVE
    2. INDETERMINATE
    9. UNKNOWN

44. IF POSITIVE, HIV STATUS FROM
    1. MEDICAL DOCUMENTATION
    2. PATIENT HISTORY
    9. UNKNOWN

IMMUNOSUPPRESSION

45. A. OTHER IMMOSUPPRESSION 1=Y 2=N 9=U
    (diabetics, ESRD, steroids for prolonged periods, chemotherapy for malignancy)
    B. IF YES, TYPE OF IMMUNOSUPPRESSION

CULTURES

46. INITIAL CULTURE DONE PER RECORD 1=Y 2=N 9=U
47. INITIAL SUSCEPTIBILITY TESTING DONE PER REC 1=Y 2=N 9=U
48. IF YES, DATE OF ISOLATE COLLECTION FOR WHICH SUSCEPTILIBILITY TESTING DONE ___/___/_____
49. IF YES,
    A. ISONIAZID RESISTANT 1=Y 2=N 9=U
    B. RIFAMPIN RESISTANT 1=Y 2=N 9=U

50. ANY CHANGE IN DRUG SUSCEPTIBILITIES DURING COURSE OF TREATMENT 1=Y 2=N 9=U

51. IF YES, DATE OF ISOLATE COLLECTION FOR WHICH SUSCEPTILBILITY TESTING DONE ___/____/_____

52. IF YES,
    A. ISONIAZID RESISTANT 1=Y 2=N 9=U
    B. RIFAMPIN RESISTANT 1=Y 2=N 9=U

53. SPUTUM COLLECTION CLOSEST TO 3 MONTHS AFTER BEGINNING THERAPY 1=Y 2=N 9=U

54. IF YES, DATE OF SPUTUM COLLECTION ___/___/_____

55. IF YES,
    A. SMEAR POSITIVE 1=Y 2=N 9=U
    B. CULTURE POSITIVE 1=Y 2=N 9=U

56. IF CULTURE NEGATIVE, IS THIS ONE OF THREE CONSECUTIVE SPUTUMS W/ NEGATIVE CULTURES? 1=Y 2=N 9=U

CXRS

57. INITIAL CHEST X-RAY 1=Y 2=N 9=U
58. IF YES, DATE ___/____/_____
59. IF YES
    1 = CAVITARY 2 = NONCAVITARY, C/W TB
    3 = NONCAVITARY, NOT C/W TB 4 = NORMAL
    5 = ABNORMAL, NOT FURTHER SPECIFIED

60. IF YES, BILATERAL DISEASE REPORTED 1=Y 2=N 9=U
61. FOLLOW-UP CHEST X-RAY PERFORMED 1=Y 2=N 9=U
62. IF YES, DATE OF CHEST X-RAY CLOSEST TO 3 MONTHS AFTER BEGINNING THERAPY ___/____/_____
63. IF YES 1 = CAVITARY 2 = NONCAVITARY, C/W TB
    3 = NONCAVITARY, NOT C/W TB 4 = NORMAL
64. COMPARED TO FIRST X-RAY:
    1 = STABLE 2 = WORSENING 3 = IMPROVING 9 = UNKNOWN
65. IF YES, BILATERAL DISEASE REPORTED 1=Y 2=N 9=U

PROVIDER TYPE

66. TYPE OF OUTPATIENT CARE PROVIDED
    1. THROUGH PUBLIC CLINICS AND CONSULTANTS ONLY
    2. PRIVATELY WITH NO CONSULTATION WITH PUBLIC CONSULTANTS
    3. PRIMARY CARE FOR TB GIVEN BY PRIVATE PROVIDER, BUT CONSULTATION BY PUBLIC TB PROGRAM AND/OR DOT BY PUBLIC PROGRAM

JUSTIFICATION

67. PROVIDERS DOCUMENTED JUSTIFICATION FOR PROLONGING THERAPY (ONE OR MORE)
    1. LACK OF ADHERENCE
    2. HIV
    3. IMMUNOSUPPRESSION
    4. POOR RESPONSE TO TREATMENT
    5. DRUG INTOLERANCE
    6. ACQUIRED DRUG RESISTANCE
    7. PROLONGED PRESECRIPTION OF MEDICATIONS BY PROVIDER, NO JUSTIFICATION EVIDENT FROM MEDICAL RECORD
    8. OTHER (SPECIFY)

68. ADDITIONAL COMMENTS